Coding for the Practitioner

Prepared for

Coalition of State Rheumatology Organizations'

National Rheumatology Fellows Conference

San Francisco, CA

February 9, 2019

Presented by: Jean Acevedo, LHRM, CPC, CHC, CENTC, AAPC Fellow

Disclaimer

- The information enclosed was current at the time it was presented. Medicare and other payer policy changes frequently. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.
- Acevedo Consulting Inc. employees, agents, and staff make no representation, warranty, or guarantee that this compilation of information is error-free and will bear no responsibility or liability for the results or consequences of the use of this information.
- This presentation is a general summary that explains certain aspects of the Medicare Program and other reimbursement and coding information, but is not a legal document. The official CPT® codes and Medicare Program provisions are contained in the relevant documents.

Agenda

- Payer Documentation Requirements
- Medical Necessity
  - a/k/a being able to keep the money!
- Evaluation and Management Services
- Common Documentation errors
- Changes to come…

“10 Iron Rules of Medicare”*

* Quote from Attorney Larry Oday; Modern Healthcare, June 19, 2000

1. Just because it has a code, that doesn’t mean it’s covered.
2. Just because it’s covered, that doesn’t mean you can bill for it.
3. Just because you can bill for it, that doesn’t mean you’ll get paid for it.
4. Just because you’ve been paid for it, that doesn’t mean you can keep the money.
5. Just because you’ve been paid once, that doesn’t mean you’ll get paid again.
6. Just because you got paid in one state doesn’t mean you’ll get paid in another state
7. You’ll never know all the rules.
8. Not knowing the rules can land you in the slammer.
9. There’s always some schlemiel who doesn’t get the message.
10. There’s always some schmendrik (jerk) who gets the message and ignores it.

Payer Documentation Requirements

Medical Record Documentation

Validates

- The site of service
  - Is it appropriate for the service and patient's condition?
- The appropriateness of the services provided
  - Not experimental
  - Meets but doesn't exceed patient's medical need
  - Ordered and performed by qualified personnel
- The accuracy of the billing
  - CPT®/HCPCS codes accurately represent what is documented
  - ICD-10-CM codes are supported by clinical documentation
- Identity of the care giver (provider)
  - Who personally performed the service?
  - Legible signature

Medical Necessity

Medicare law requires that in order for expenses incurred for items or services to be covered, they must be "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

CMS Glossary for Beneficiaries defines medical necessity as: “Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren’t mainly for the convenience of you or your doctor. “

So, in plain English

- Think of Medicare as any other health insurance
- Certain items/services are covered
  - And others are not
- And those that are, must meet the coverage criteria
  - That the service is “reasonable and necessary” or be one of the preventive benefits
- Much of this is defined in NCDs and LCDs for non-E&M services provided by Rheumatologists

Evaluation & Managements Basics

E&M Coding…what the ??

- Where am I?
  - Inpatient, home, SNF/NF, office codes
- Is this a new or established patient visit (inpatient/outpatient)?
- Or is this the initial or subsequent visit for this admission (hospital/inpatient)?
- Once you answer those questions…
  - 3, 4 or 4 levels of service to choose from

CPT®: E&M Services Guidelines

New and Established Patient

- "solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report [E&M] services…
- "an established patient is one who has received professional services from the physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice within the past three years.
- "…where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician."

7 Components Define E&M Services

- Key components in selection of level
  - History
  - Examination
  - Medical decision making
- Ancillary elements in selection of care
  - Counseling
  - Coordination of care
  - Nature of presenting problem (medical necessity
  - Time

Use of Time

If a visit consists **predominantly** of counseling and/or coordination of care, time is the key element to assign the appropriate level of E&M service.

- Office/outpatient setting
  - Face-to-face time refers to patient time with the physician only
  - Counseling by other staff does not count
  - Duration of counseling and/or coordination of care may be estimated but must be recorded
  - Total duration of the visit also documented
  - Do not round up!
    - 99214 = 25 minutes
    - 99215 = 40 minutes
    - 35 minute visit is a 99214

“Results” Visit

At least 45 minutes with patient >50% discussing lab results, lifestyle changes and medications to help manage symptoms; new diagnosis of Lupus. All patient questions answered. Long discussion regarding her desire to get pregnant.

Coding using the 3 Key Components

1. History
2. Physical Exam
3. Medical Decision Making

Level 3 E&M

<u>New patient visit/consults</u>

- 99203/99243/99253
  - Detailed history
    - HPI – 4+
    - ROS – 2-9
    - PFSH – 2:3
  - Detailed exam
    - 2-7 BA/OS
  - Medical decision making of low complexity

<u>Established Patient Office Visit</u>

- 99213
  - Expanded Problem Focused history
    - HPI 1-3
    - ROS – 1
    - Expanded Problem Focused exam
      - 2-7 BA/OS
    - Medical decision making of low complexity

99204/99244
Documentation Required (all of the below*)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g., location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past, family and social history - something from each of these
2. Comprehensive Exam (8 or more organ systems)
3. Medical decision making of Moderate complexity (at least 2 of the following variables)
   - Moderate number of diagnoses or management options
     - New problem with or without a work-up
   - Moderate amount of complexity of data (to be) reviewed
   - Moderate degree of risk
     - Prescription drug management

* *If even one element is not documented (9 systems in the review of systems, "Family Hx: Noncontributory,", etc., the payer could down code you*

99205/99245
Documentation Required (all of the below*)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g., location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past, family and social history - something from each of these
2. Comprehensive Exam (8 or more organ systems)
3. Medical decision making of **High** complexity (at least 2 of the following variables)
   - Extensive number of diagnoses or management options
     - New problem with a work-up
   - Extensive amount of complexity of data (to be) reviewed
     - Reviewed or ordered lab, caregiver/spouse contributed to history, reviewed/ordered x-ray
   - High degree of risk

* *If even one element is not documented (9 systems in the review of systems, "Family Hx: Noncontributory,", etc., the payer could down code you*

99214
Documentation Required (2:3 Key Components)

1. Detailed History
   - Chief complaint
   - HPI (4 or more elements; e.g., location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past, family and social history - something from 1 of each of these
     - Listing medications = medical history
2. Detailed* (extended exam of 2-7 body areas/organ systems)
3. Medical decision making of **High** complexity (at least 2 of the following variables)
   - Extensive number of diagnoses or management options
     - New problem with a work-up
   - Extensive amount of complexity of data (to be) reviewed
   - Moderate degree of risk
     - Prescription drug management

* *Interpretation of "extended" varies by payer. From 2 elements for at least 2 body areas or 2 organ systems (PalmettoGBA), to at least 4 elements of at least 4 body areas or 4 elements of at least 4 organ systems (Novitas).*

Changes to E&M Documentation and Coding:

1) Impacts only Office Visits

2) Medicare only (at this point)

Finalized: Office Visits as of January 1, 2019

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit
- For Est. Pt OVs, “when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.”

Change Request 11063, released 11/30/18

Finalized: Office Visits as of January 1, 2019

- “..for new and established patients…practitioners need not re-enter in the medical record information on the patient’s chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the record that he or she reviewed and verified this information”

Change Request 11063, released 11/30/18

Finalized: Office Visits as of January 1, 2021

- Reduction in the payment variation for E/M office/outpatient visit levels by paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients
- Permitting practitioners to choose to document E/M office/outpatient level 2 through 5 visits using Medical Decision Making (MDM) or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework
- Beginning in CY 2021, for E/M office/outpatient levels 2 through 5 visits, CMS will allow for flexibility in how visit levels are documented— specifically a choice to use the current framework, MDM, or time. For E/M office/outpatient level 2 through 4 visits, when using MDM or current framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or MDM.

MLN Matters MM11063, released 11/30/18

Finalized: Office Visits as of January 1, 2021

- “Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be resitricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements; and
- “Adoption of a new “extended visit” add-on code for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient.”

MLN Matters MM11063, released 11/30/18

Changes to E&M Codes in the Future

- “We agree with continued feedback from stakeholders that these guidelines are potentially outdated and need to be revised.”
- “CMS is seeking comment from stakeholders on specific changes we should undertake to update the guidelines, to reduce the associated burden, and to better align E/M coding and documentation with the current practice of medicine. We are especially seeking comment on how we might focus on initial changes to the guidelines for history and exam, because we believe documentation for these elements may be more significantly outdated.”

All physicians and staff should keep their eyes and ears open and be willing to provide input via their specialty societies, CSRO, CMS, etc.

Common Documentation Errors

- Services were rendered by one provider and billed by another provider
  - Understand incident-to and shared visit billing
  - You must be in the office suite for ancillary staff's services to be billed under your name and NPI for "incident to" billing
  - If employing an ARNP/CNS or PA
    - They MUST have their own Medicare number
    - Cannot bill their visits under you ("incident-to") if they see a new patient
      - Or they see an established patient with a new problem, or if they change anything
    - Check private/managed care payers' criteria

Common Documentation Errors

- Conflicting information in the medical record
  - The diagnosis on the claim is not consistent with the diagnosis in the medical record
  - “denies erectile dysfunction” female patient’s review of systems
  - Review of systems states “denies knee pain,” in a patient presenting with knee pain as the chief complaint
- Date of service in the documentation is different from the date of service billed
- Medical documentation does not support medical necessity for the frequency of the visit
  - 99214 every 3 weeks for a stable patient
  - If ICD-10 is reported correctly, the patient may not be quite so “stable”
- Documentation does not support the payer’s requirements for coverage (payment)
  - 3 or more months of more conservative treatment for Viscosupplementation, for example

Briefly: Medical Necessity and EMRs

- Documentation software may facilitate carry-overs and repetitive fill-ins of stored information
- Even when a “complete” note is generated, only medical necessary services for condition of patient at time of encounter as documented can be considered when selecting appropriate level of E/M service
- Information not pertinent to patient’s condition at time of encounter cannot be counted
  - Patient is seen in ‘routine’ follow-up of stable OA. History is “comprehensive” including past, family and social history. Was it “medically necessary” to repeat these history elements?

New for 2019

G2010 - Remote pre-recorded services

New Medicare Covered Service

- G2010 - Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
- In layman's terms: Remote evaluation services when a physician uses pre-recorded video and/or images submitted by a patient in order to evaluate a patient's condition

- ~$13.00

G2012 – Virtual Check-in Service

New Medicare Covered Service

- G2012 - Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. [emphasis added]
- Call/other communication must be initiated by the patient.
- Established patients only
- Interaction only with the physician/QHP, no other clinical staff.
- Verbal consent by the patient for each virtual check-in must be documented in the medical record.
- ~$15

CPT®: Radiology Revised Guidelines for 2019

- S&I and Imaging Guidance:
  - All imaging guidance requires 1) image documentation in the patient record and 2) description of imaging guidance in the procedure report
  - All S&I codes require 1)image documentation in the patient's permanent record and 2) a procedure report or separate imaging report that includes written documentation of interpretive findings of information contained in the images and radiologic supervision of the service.
- Written Report(s)
  - With regard to CPT® descriptors for imaging services, "images" must contain anatomic information unique to the patient for which the imaging service is provided.

Bone Mass Measurements (CPT 77085)

- 77085: Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites, axial skeleton, (e.g., hips, pelvis, spine), including vertebral fracture assessment).
- Effective 4/1/2019 for claims with dates of service on and after Jan 1, 2015
- Medicare waives the deductible and coinsurance for BMM code 77085
  - Has waived these for 77080 since 2015.
- “Contractors shall not search for claims containing code 77095 with dates of service on or after January 1, 2015, that are processed on or after April 1, 2019, but contractors may adjust claims that are brought to their attention.”

CMS Transmittal 4150; CR 10956

Questions??

Jean Acevedo, LHRM, CPC, CHC, CENTC, AAPC Fellow
Acevedo Consulting Incorporated
2065 West Atlantic Avenue, Suite D-102
Delray Beach, Florida 33445
561.278-9328

info@acevedoconsulting.com

www.acevedoconsultinginc.com